

28

13816

13879

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X

MEDICAL CERTIFICATION

1910

CERTIFICATE OF DEATH

1910

Name of Deceased		Sex		Age		Date of Death		Place of Death	
Alvin Anderson		Male		37		Nov. 20		New York	
Residence		Occupation		Cause of Death		Manner of Death		Signature of Physician	
New York		Laborer		Heart Disease		Natural		J. J. Jones	
Place of Birth		Color		Marital Status		Religion		Signature of Registrar	
Sweden		White		Single		Lutheran		J. J. Jones	
Date of Birth		Date of Marriage		Date of Last Examination		Date of Last Vaccination		Signature of Registrar	
Nov. 10, 1873		None		None		None		J. J. Jones	
Date of Death		Date of Burial		Date of Interment		Date of Cremation		Signature of Registrar	
Nov. 20, 1910		Nov. 22, 1910		Nov. 22, 1910		None		J. J. Jones	
Place of Burial		Place of Interment		Place of Cremation		Place of Burial		Signature of Registrar	
New York		New York		New York		New York		J. J. Jones	
Date of Death		Date of Burial		Date of Interment		Date of Cremation		Signature of Registrar	
Nov. 20, 1910		Nov. 22, 1910		Nov. 22, 1910		None		J. J. Jones	
Place of Burial		Place of Interment		Place of Cremation		Place of Burial		Signature of Registrar	
New York		New York		New York		New York		J. J. Jones	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

13841

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13817

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>346 East Third Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie VanFossen Atkinson</b>				4. DATE OF DEATH Month Day Year <b>December 1, 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 11, 1881</b>	
9. AGE (In years lost birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>W. Scott VanFossen</b>		14. MOTHER'S MAIDEN NAME <b>Harriet L. Dutrow</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Paul S. Micheal 216 Lindbergh Ave. Fred.Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF COLON</b> 153-8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>7/</b> <b>1960</b> to <b>11/30</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>11/30</b> <b>1960</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard C. Reynolds</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/1/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Richard C. Reynolds</b>				M.D. <b>9 East Church Street Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 3, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dailey Jr.</b>				ADDRESS <b>Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 5 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>	

1887

CERTIFICATE OF DEATH

<p>Dec. 5, 1887</p> <p>Attest, my hand and seal of office, this 5th day of December, 1887.</p> <p>Notary Public for the State of New York.</p>	<p>Dec. 5, 1887</p> <p>Attest, my hand and seal of office, this 5th day of December, 1887.</p> <p>Notary Public for the State of New York.</p>	<p>Dec. 5, 1887</p> <p>Attest, my hand and seal of office, this 5th day of December, 1887.</p> <p>Notary Public for the State of New York.</p>	<p>Dec. 5, 1887</p> <p>Attest, my hand and seal of office, this 5th day of December, 1887.</p> <p>Notary Public for the State of New York.</p>
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
13842  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13818

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		d. STREET ADDRESS <u>1323 East Third Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baer</u> Middle <u>Baby</u> Last <u>Girl</u> <u>BAER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-60</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Donald Baer</u>		14. MOTHER'S MAIDEN NAME <u>Emma Irene Ditterman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father - 223 East Third St</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Prematurity (cause unknown)</u> DUE TO (c) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 24, 1960</u> to <u>Dec. 24, 1960</u> that (I) (we) last saw the deceased alive on <u>Dec. 24, 1960</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard O. Thomas Jr.</u>		22b. DATE <u>12/24/1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bernard O. Thomas, Jr., M.D.</u>		22d. ADDRESS <u>Frederick, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 27, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		25a. REC'D BY REGISTRAR <u>442800</u>	
ADDRESS <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hane</u>	

2069181XV2

CERTIFICATE OF ANALYSIS

1931

ANALYSIS OF  
[Faint, illegible text follows, likely describing the sample and analysis results.]



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13880 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13819

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Windsor, Rural</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Windsor, Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 2</b>			d. STREET ADDRESS <b>Route 2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Theodore</b> Last <b>Bair</b>			4. DATE OF DEATH Month <b>December</b> Day <b>28</b> , Year <b>19 60</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18, 1881</b>		9. AGE (In years last birthday) <b>79</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>millner, grinding</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>feed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			13. FATHER'S NAME <b>George E. Bair</b>		
14. MOTHER'S MAIDEN NAME <b>Annie Riggle</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		
16. SOCIAL SECURITY NO. <b>212-14-6418</b>			17. INFORMANT <b>Mrs. Daisy Condon, Mt. Airy, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation by hanging</b> <b>974X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Suicide</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/28/60</b>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, MD.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/31/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Winfield, Md.</b>		22e. REC'D BY REGISTRAR <b>Jan 3 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. E. Hartzler &amp; Sons, New Windsor, Md.</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





CERTIFICATE OF DEATH

Reg. Dist. No.

13881

13820

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EN ROUTE</b>				c. LENGTH OF STAY IN 1b <b>TO</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HILDA EAVS BOHN</b>				4. DATE OF DEATH Month Day Year <b>DEC 12 1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 17 - 1900</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DANIEL O METZ</b>				14. MOTHER'S MAIDEN NAME <b>OLIVIA EAVS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT Address <b>DAVID R BOHN UNION BRIDGE MD</b> <b>R2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b> 744-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>muscular dystrophy</b> DUE TO (c) <b>2 year</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1939</b> to <b>Dec 12 1960</b> that I last saw the deceased alive on <b>Dec 12 1960</b> , and that death occurred at <b>6:00</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. H. MESSLER</b> M.D.				ADDRESS (Street, city or town, state) <b>Union Bridge MD 21660</b> DATE SIGNED <b>DEC 16 '60</b>			
PHYSICIAN'S NAME (Type) <b>J. H. MESSLER, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/15/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BEAVER DAM</b>		22d. LOCATION (City, town, or county) (State) <b>FREDERICK CO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. Hartzler</b> ADDRESS <b>Union Bridge, Md</b>				24a. REC'D BY REGISTRAR <b>DEC 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13821

13871

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Frederick</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>		c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Brunswick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 East E St.</u>				d. STREET ADDRESS <u>1 East E St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lulu</u> Middle <u>E.</u> Last <u>Brown</u>				<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/31/1885</u>	
9. AGE (In years lost birthday) <u>75 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Gordon</u>				14. MOTHER'S MAIDEN NAME <u>Nancy ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT <u>Mrs. Glenn Sowers, Brunswick, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>4 43X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. } (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 31, 1958</u> to <u>Dec. 9, 1960</u> that (I) (we) lost saw the deceased alive on <u>Dec. 9, 1960</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>C.T. Byron Kao</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Dec 10 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>C.T. Byron Kao, M.D.</u>				22d. ADDRESS <u>15 S. Maryland Ave., Brunswick, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>12/11/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company,</u>				ADDRESS <u>Middletown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 13 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruess</u>			

1. The purpose of this report is to provide a summary of the results of the research conducted by the American Air Force Institute of Research, Department of Defense, on the subject of the effects of the use of the atomic bomb on the human population.

2. The research was conducted by a team of scientists and engineers who were members of the American Air Force Institute of Research, Department of Defense, and who were assigned to the project by the Air Force Research and Development Command, Office of the Chief of Staff, Air Force, United States Department of Defense.

3. The research was conducted in the form of a series of experiments and observations which were designed to determine the effects of the use of the atomic bomb on the human population. The results of the research are summarized in this report.

4. The research was conducted in the form of a series of experiments and observations which were designed to determine the effects of the use of the atomic bomb on the human population. The results of the research are summarized in this report.

5. The research was conducted in the form of a series of experiments and observations which were designed to determine the effects of the use of the atomic bomb on the human population. The results of the research are summarized in this report.

6. The research was conducted in the form of a series of experiments and observations which were designed to determine the effects of the use of the atomic bomb on the human population. The results of the research are summarized in this report.

7. The research was conducted in the form of a series of experiments and observations which were designed to determine the effects of the use of the atomic bomb on the human population. The results of the research are summarized in this report.

8. The research was conducted in the form of a series of experiments and observations which were designed to determine the effects of the use of the atomic bomb on the human population. The results of the research are summarized in this report.

9. The research was conducted in the form of a series of experiments and observations which were designed to determine the effects of the use of the atomic bomb on the human population. The results of the research are summarized in this report.

10. The research was conducted in the form of a series of experiments and observations which were designed to determine the effects of the use of the atomic bomb on the human population. The results of the research are summarized in this report.

## CERTIFICATE OF DEATH

Reg. Dist. No.

13822

13872

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	
c. LENGTH OF STAY IN lb <b>15 years</b>		d. STREET ADDRESS <b>111 East "A" Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>West "B" Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Thomas</b> Middle <b>Bush</b> Last		4. DATE OF DEATH Month <b>12</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-1895</b>
9. AGE (In years last birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Apartment House</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Un Known</b>		14. MOTHER'S MAIDEN NAME <b>Susan Bush</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-12-0912</b>	
17. INFORMANT <b>James Beamer, Brunswick, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>chronic pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>11 years L-V-R disease</b> DUE TO (c) <b>10 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-14-1960</b> to <b>12-16-1960</b> , that I last saw the deceased alive on <b>12-16-1960</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brunswick, Md 12-16-60</b> DATE SIGNED			
ACTUAL SIGNATURE <b>C.E. Pruitt</b>		M.D. <b>Brunswick, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>C.E. Pruitt</b>		<b>Brunswick Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-17-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley</b>	22d. LOCATION (City, town, or county) (State) <b>Garretts Mills, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Pruitt</b>		ADDRESS <b>Brunswick, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1922



STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

1922

1922

1922

1922

1922

1922

1922



13843

## CERTIFICATE OF DEATH

Reg. Dist. No.

13823

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>Maryland</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Eugene</b> Last <b>Cordell</b>				4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1918</b>	9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>5</b> Hours <b>2</b> Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Road Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eugene Cordell</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Beall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>218-10-9738</b>		INFORMANT <b>Mrs. Edward E. Cordell</b>		Address <b>Same as 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC-HYPERTENSIVE CARDIOVASCULAR DISEASE</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>ACUTE CARDIAC DECOMPENSATION</b> DUE TO (c) <b>CIRRHOSIS OF THE LIVER</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 year - 3 DAYS - 6 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/12</b> , 19 <b>60</b> , to <b>12/15</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/14</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>James P. Kerr</b> M.D. <b>Damascus, Md.</b> ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED <b>12/15/60</b> PHYSICIAN'S NAME (Type) <b>Dr. James P. Kerr</b> <b>Damascus, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-17-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Clarksburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Montgomery County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 19 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1943

CERTIFICATE OF DEATH

1943

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Place of birth: \_\_\_\_\_  
6. Date of death: \_\_\_\_\_  
7. Place of death: \_\_\_\_\_  
8. Cause of death: \_\_\_\_\_  
9. Signature of physician: \_\_\_\_\_  
10. Signature of registrar: \_\_\_\_\_  
11. Date of registration: \_\_\_\_\_

Burial

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13844

13824

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lewistown, Maryland</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>				e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Arthur</i> Middle <i>W.</i> Last <i>Crebbs</i>				4. DATE OF DEATH Month <i>DECEMBER</i> Day <i>2</i> Year <i>1960</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/9/1897</i>	
9. AGE (In years last birthday) <i>63</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Business</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>David Lee Crebbs</i>				14. MOTHER'S MAIDEN NAME <i>Minnie Esley</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-32-4343</i>		17. INFORMANT <i>Mrs. Julia Crebbs</i>		Address <i>Lewistown, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of colon with widespread metastases</i> 153-8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>Nov. 30 - Dec. 2</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 30</i> 19 <i>60</i> , to <i>Dec. 2</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>Dec. 2</i> 19 <i>60</i> , and that death occurred at <i>10:15</i> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <i>A. A. Pearre</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>12/2/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>A. A. Pearre</i>				22d. ADDRESS <i>4 E. Church St., Frederick Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-6-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lewistown Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Lewistown, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Truax</i>				ADDRESS <i>Thurmont, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 6 '60</i>	
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13825

13845

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Frederick-Rural-R.F.D.#5</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital, D.O.A.</b>				d. STREET ADDRESS <b>/Ronud Hill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>BOUCHER</b> Last <b>CROTHERS</b>				4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 21, 1893</b>	
9. AGE (In years lost birthday) yrs. <b>67</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired President</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Line Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William J. Crothers</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Boucher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW1 217-10-9400</b>		17. INFORMANT <b>Mrs. Adelle S. Crothers, Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>10 years</b> (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>60</b> to <b>Dec.</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/23</b> 19 <b>60</b> , and that death occurred at <b>5:20</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard C. Reynolds,</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/24/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard C. Reynolds, M.D.</b>				22d. ADDRESS <b>EastChurch Street, Frederick, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/27/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>DEC 28 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MAINTAIN AND ATTEST DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH AND VETERINARY MEDICINE  
CERTIFICATE OF DEATH

1900

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Place of birth: \_\_\_\_\_  
6. Date of death: \_\_\_\_\_  
7. Cause of death: \_\_\_\_\_  
8. Signature of attending physician: \_\_\_\_\_  
9. Signature of registrar: \_\_\_\_\_  
10. Date of registration: \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13846  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13826  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>15 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>700 East Patrick Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IRVIN</b> Middle <b>FRANKLIN HILL</b> Last <b>CROUSE</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> , 19 <b>60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1905</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deputy Sheriff &amp; Turnkey County Jail</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis Edward Crouse</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Wilhide</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-2970</b>	
17. INFORMANT <b>Mrs. Elsie E. Crouse-Same as item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>15 Days</b> <b>4-5 years</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 27, 1960</b> to <b>Dec 26, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 26, 1960</b> , and that death occurred at <b>1205A</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry V. Chase</b>		22b. DATE SIGNED <b>12/27/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M.D.</b>		22d. ADDRESS <b>East Church Street, Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. RECEIVED BY REGISTRAR <b>12/28/60</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hwang</b>	



TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 13847 <b>CERTIFICATE OF DEATH</b> 13827									
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. LENGTH OF STAY IN lb <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>312 East Second Street</b>					d. STREET ADDRESS <b>312 East Second Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ORZULA</b> Middle <b>CATHERINE</b> Last <b>CRUM</b>					4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1960</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 5, 1876</b>		9. AGE (In years last birthday) yrs. <b>84</b>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mahlon B. Green</b>					14. MOTHER'S MAIDEN NAME <b>Mary Ann Hoffman</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. Mahlon L. Crum— Same as Item #2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>260X</b> IMMEDIATE CAUSE (a) <b>Symptoms</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes mellitus</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1960</b> , to <b>Dec 4 1960</b> , that (I) (we) last saw the deceased alive on <b>August 1960</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Rex R. Martin</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/6/1960</b>		
22c. PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M. D.</b>					22d. ADDRESS <b>North Market Street, Frederick, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 7, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>					25a. REC'D BY REGISTRAR <b>DEC 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		

15327

15327

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of birth: *Jan 15, 1900*  
5. Place of birth: *New York City*  
6. Date of death: *Dec 10, 1945*  
7. Place of death: *New York City*  
8. Cause of death: *Heart disease*  
9. Signature of physician: *John Doe*  
10. Signature of registrar: *John Doe*

*John Doe*  
*John Doe*

*John Doe*  
*John Doe*

## CERTIFICATE OF DEATH

Reg. Dist. No. 13828

13848

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>14 Hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CARRIE</b> Middle <b>REBECCA</b> Last <b>DEGRANGE</b>				4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11 Feb 1891</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Clifford S. Smith</b>				14. MOTHER'S MAIDEN NAME <b>America Jane King</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lloyd S. DeGrange (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> 420.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>5 yrs +</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11/30</b> , 19 <b>60</b> , to <b>12/1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/1</b> , 19 <b>60</b> , and that death occurred at <b>2:30A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St.</b> DATE SIGNED <b>1 Dec 60</b>							
ACTUAL SIGNATURE <b>Henry V Chase</b>				M.D. <b>Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-3-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Jefferson, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL by the attending physician: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13849

Item 8

CERTIFICATE OF DEATH

13829

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Frederick</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hos.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick New Market</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>DONOVAN</b> Last <b>1</b>		4. DATE OF DEATH Month <b>Dec. 31</b> Day <b>1960</b> Year <b>19</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1897</b>	9. AGE (In years last birthday) <b>63</b>	10. IF UNDER 1 YEAR Months <b>7</b>	11. IF UNDER 24 HRS. Days <b>19</b>	12. IF UNDER 24 HRS. Hours <b>19</b>	13. IF UNDER 24 HRS. Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-28-7048</b>		17. INFORMANT <b>Harry Delawder, Woodbine, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive Heart Failure</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>November 1960</b> to <b>Dec 31</b> , 1960 that (I) <del>was</del> last saw the deceased alive on <b>Dec 31</b> , 1960 and that death occurred at <b>6 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Charles S. Putnam Jr.</b>		22b. DATE SIGNED <b>1</b>		22c. PHYSICIAN'S NAME (Type) <b>Charles S. Putnam Jr.</b>		22d. ADDRESS <b>M.D. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/></b>		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lisbon</b>		23d. LOCATION (City, town, or county) <b>Lisbon, Md</b>		23e. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Putnam</b>		25c. REGISTRAR'S SIGNATURE <b>Charles S. Putnam</b>		25d. REGISTRAR'S SIGNATURE	

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CERTIFICATE OF DEATH

Reg. Dist. No.

13850

13830

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>10 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>302 Middle Street</b>				d. STREET ADDRESS <b>302 Middle Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Henrietta Nettie Debra Dorsey</b>				4. DATE OF DEATH <b>Dec. 19 19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 12-1891</b>	
9. AGE (In years lost birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Rice Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Martha Penn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-30-9035A</b>		INFORMANT <b>Louise Henry-302 Middle St. Fred. Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Cerebral vascular accident</b> DUE TO (b) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>11-1-1959</b> to <b>12-19-1960</b> that I last saw the deceased alive on <b>12-17-1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Rex Martin</b> M.D. PHYSICIAN'S NAME (Type) <b>Rex Martin</b> <b>Market St. Frederick - Maryland</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>12-22-60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b> 22d. LOCATION (City, town, or county) (State) <b>Libertytown-Fred. Co. Md.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks 111</b> ADDRESS <b>Frederick, Md.</b> 24a. REC'D BY REGISTRAR <b>JAN 4 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13882 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13831

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 26</u>	c. LENGTH OF STAY IN 1b <u>5 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Unionville Route 26</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oscar Calvin Doub</u>		4. DATE OF DEATH Month Day Year <u>December 12 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1906</u> 54 yrs.
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Drug Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pittsburg, Pa</u>	11. BIRTHPLACE (State or foreign country) <u>Pa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Oscar E. Doub</u>	
14. MOTHER'S MAIDEN NAME <u>Janina Johnson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-09-8745</u>		17. INFORMANT Address <u>Mrs Izorah Doub Mdary Rd 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 12, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henny Lander &amp; Sons, Inc</u>		24a. REC'D BY REGISTRAR <u>Balto 13</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1388

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF DEATH  
5. PLACE OF DEATH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. MANNER OF DEATH  
9. SIGNATURE OF EXAMINER  
10. SIGNATURE OF WITNESSES  
11. SIGNATURE OF FUNERAL HOME  
12. SIGNATURE OF CORONER  
13. SIGNATURE OF JUDGE  
14. SIGNATURE OF CLERK  
15. SIGNATURE OF NOTARY  
16. SIGNATURE OF ATTORNEY  
17. SIGNATURE OF PHYSICIAN  
18. SIGNATURE OF NURSE  
19. SIGNATURE OF CHURCH  
20. SIGNATURE OF OTHER





1935

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13883

CERTIFICATE OF DEATH

Reg. Dist. No. 13833

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Ijamsville</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Riggs Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>STOKES</b> Last <b>ENGELBRECHT</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 18 1894</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cleaning Firm</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank M. Stokes</b>		14. MOTHER'S MAIDEN NAME <b>Florence V. Topper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-10-9212</b>	
17. INFORMANT <b>Mr. Beverly M. Angelbrecht (Same as item #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 491x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 29</b> , 1960, to <b>Dec 1</b> , 1960 that I last saw the deceased alive on <b>Dec 1</b> , 1960, and that death occurred at <b>5:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph Lerner</b> M.D.		ADDRESS (Street, city or town, state) <b>Ijamsville</b> DATE SIGNED <b>12/1/60</b>	
PHYSICIAN'S NAME (Type) <b>Joseph Lerner</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-5-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 5 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13852  
13834  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Since 10-15-60</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>610 Schley Avenue</b>		e. STREET ADDRESS <b>610 Schley Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>MALINDA</b> Last <b>FLOOK</b>		4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 July 1881</b>
9. AGE (In years and birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George H. Tritapoe</b>		14. MOTHER'S MAIDEN NAME <b>Vandelia Castle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-38-7607</b>	
17. INFORMANT <b>Howard O. Flook, Sr. (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO VASCULAR ACCIDENT</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>one hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/4</b> 19 <b>60</b> to <b>12/12</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred on <b>12</b> A M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard C. Reynolds, M.D.</b>		22b. DATE <b>13 Dec 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard C. Reynolds, M. D.</b>		22d. ADDRESS <b>9 E. Church St., Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-15-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Burkittsville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 15 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Richard C. Reynolds</b>			

CERTIFICATE OF DEATH

1982

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Cause of death		9. Place of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of medical examiner		14. Signature of coroner		15. Signature of funeral director	
16. Signature of health officer		17. Signature of local health officer		18. Signature of state health officer		19. Signature of federal health officer		20. Signature of other official	



13884

## CERTIFICATE OF DEATH

Reg. Dist. No. 13835

1. PLACE OF DEATH o. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Midway</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Midway</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Life</i>				d. STREET ADDRESS <i>1</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>WALTER</i> Middle <i>CLETUS</i> Last <i>FOGLE</i>				4. DATE OF DEATH Month <i>Dec.</i> Day <i>17</i> Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 29 1877</i>	9. AGE (In years lost birthday) <i>83</i> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Live stock dealer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own business</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Milton Isaac Fogle</i>				14. MOTHER'S MAIDEN NAME <i>Mary Catherine Clark</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mrs John Dwyer, Rocky Ridge, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crown aneurysm</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i>hypertension</i> DUE TO (c) <i>arteriosclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>Dec 1</i> , 19 <i>60</i> to <i>Dec 17</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Dec 10</i> , 19 <i>60</i> , and that death occurred at <i>9</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Union Bridge Md</i> DATE SIGNED <i>Dec 17 1960</i>							
ACTUAL SIGNATURE <i>J. H. MESSLER</i> M.D.				PHYSICIAN'S NAME (Type) <i>J. H. MESSLER M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/20/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Naughts</i>		22d. LOCATION (City, town, or county) (State) <i>M. Ladiesburg Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton</i> ADDRESS <i>Walkersville, Md</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 23 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13853

## CERTIFICATE OF DEATH

Reg. Dist. No.

13836

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ROCK RIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL Hospital</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>STEVEN CRAIG FRUSHOUR</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER 3 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 1, 1960</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>1 10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Robert Frushour</u>		14. MOTHER'S MAIDEN NAME <u>MARY GERALDINE BREEDEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Charles R. Frushour Rocky Ridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 750 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Encephalitis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 1, 1960</u> , to <u>December 3, 1960</u> , that I last saw the deceased alive on <u>December 3, 1960</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>DR. F. J. HELDRICK</u> <u>Frederick Medical Center</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-3-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Crease</u> ADDRESS <u>Thurmont, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



1  
13854  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13837

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>James C. Gamber</b>		4. DATE OF DEATH <b>Dec 27 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1886</b>
9. AGE (In years on birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George W. Gamber</b>		14. MOTHER'S MAIDEN NAME <b>Christie A. Gosnell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>213-12-2043</b>	
17. INFORMANT <b>Mrs. Viola Norwood, Mt. Airy, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>3 year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/26</b> 19 <b>60</b> , to <b>12/27</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/26</b> 19 <b>60</b> , and that death occurred at <b>A. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry V. Chase</b>		22b. DATE SIGNED <b>12-27-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>		22d. ADDRESS <b>46 Church St Frederick Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-30-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Taylorville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 29 '60</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>	



1883

CERTIFICATE OF DEATH

1883

Frederick

Marshall

County

Frederick

Marshall

The County of Frederick

1883

Marshall

Frederick

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Marshall



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13885

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13838

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#2		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Overpass-U.S.#240&New Design Road		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BRUCE Middle Last GREGORY		4. DATE OF DEATH Month December Day 28, Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1903
9. AGE (In years and birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Exct.		10b. KIND OF BUSINESS OR INDUSTRY Tire Company	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Gregory		14. MOTHER'S MAIDEN NAME Della Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 298-01-4361	
17. INFORMANT Mrs. Ruth E. Gregory-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) CRUSHED CHEST (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Ran Off Road-Striking Abutment of OverPass	
20c. TIME OF INJURY Month, Day, Year 11 Hour XX p.m. 12/28/ 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Frederick, Frederick, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1/3/1961	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) Bladensburg, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE JAN 4 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1. Name of deceased: John Doe  
2. Sex: Male  
3. Age: 45  
4. Date of death: 10-1-1911  
5. Place of death: Home  
6. Cause of death: Heart disease  
7. Manner of death: Natural  
8. Signature of medical examiner: J. S. Smith  
9. Signature of coroner: W. B. Jones  
10. Signature of registrar: M. A. Brown

11. Description of death: Heart disease  
12. Description of illness: Heart disease  
13. Description of symptoms: Heart disease  
14. Description of treatment: Heart disease  
15. Description of autopsy: Heart disease  
16. Description of findings: Heart disease  
17. Description of organs: Heart disease  
18. Description of tissues: Heart disease  
19. Description of cells: Heart disease  
20. Description of molecules: Heart disease  
21. Description of atoms: Heart disease  
22. Description of particles: Heart disease  
23. Description of waves: Heart disease  
24. Description of fields: Heart disease  
25. Description of forces: Heart disease  
26. Description of energy: Heart disease  
27. Description of matter: Heart disease  
28. Description of space: Heart disease  
29. Description of time: Heart disease  
30. Description of information: Heart disease

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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13855  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13839

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>202 East Church Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>Allen</b> Last <b>GROVE</b>				4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19, 1923</b>	
9. AGE (In years lost birthday) <b>37</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brick Layer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles Preston Grove</b>				14. MOTHER'S MAIDEN NAME <b>Adelia Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>212-14-7964</b>		17. INFORMANT <b>Mrs. Beatrice E. Grove</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma with</b> DUE TO <b>generalized metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO <b></b> (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Frederick</b>				20g. (County) <b>Frederick</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>12/1</b> 19 <b>60</b> , to <b>12/2</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/2</b> 19 <b>60</b> , and that death occurred at <b>9:30</b> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <b>Henry V. Chase</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2 Dec 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>				22d. ADDRESS <b>4 E. Church St Frederick, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-5-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dailey</b>				ADDRESS <b>Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 5 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

13833

CERTIFICATE OF DEATH

Franklin

Franklin

Franklin

Franklin

Franklin

Franklin

Franklin Memorial Hospital

300 East Clinton Street

Franklin

Franklin

Franklin, December 2, 1903

Franklin

July 10, 1903

27

Franklin

Home

Franklin, Franklin

Franklin

Franklin

Franklin

Franklin

Franklin, December 2, 1903

*Franklin Memorial Hospital*  
*Franklin, Franklin*

Franklin

Franklin

Franklin

Franklin

Franklin

Franklin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13856

## CERTIFICATE OF DEATH

13840

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Brunswick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		d. STREET ADDRESS <b>1209 A Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ESTELLE</b> Middle <b>HARRIS</b> Last <b>HARRIS</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 AUG 1889</b>
9. AGE (In years last birthday) yrs. <b>71</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Harry Whitter</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Krieg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Evelyn Wollen, Buckeystown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC MYELOID LEUKEMIA</b> <b>204.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>OCT 1952</b> to <b>6 DEC 1960</b> , that I last saw the deceased alive on <b>6 DEC 1960</b> , and that death occurred at <b>10:43 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick, Md.</b> DATE SIGNED <b>12/7/60</b> ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b> M.D. <b>Prayerman Blige</b> PHYSICIAN'S NAME (Type) <b>CHARLES H. CONLEY, JR.</b> <b>Frederick, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-9-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>
22d. LOCATION (City, town, or county) (State) <b>Bealsville, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Frank</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 12 '60</b>	
ADDRESS <b>Brunswick, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



CERTIFICATE OF DEATH

PLACE OF DEATH HOME		MARRIAGE NONE	
PLACE OF BIRTH HOME		PLACE OF DEATH HOME	
DATE OF BIRTH 1900		DATE OF DEATH 1900	
SEX MALE		SEX MALE	
RACE WHITE		RACE WHITE	
OCCUPATION NONE		OCCUPATION NONE	
CAUSE OF DEATH CHRONIC MYELOID LEUKEMIA		CAUSE OF DEATH CHRONIC MYELOID LEUKEMIA	
MEDICAL HISTORY NONE		MEDICAL HISTORY NONE	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF PHYSICIAN J. H. HARRIS	
SIGNATURE OF DEATH REGISTRAR J. H. HARRIS		SIGNATURE OF DEATH REGISTRAR J. H. HARRIS	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.  
 IT IS THE DUTY OF THE DEATH REGISTRAR TO SIGN THIS CERTIFICATE AND TO FILE IT IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.  
 IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FILE IT IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.  
 IT IS THE DUTY OF THE DEATH REGISTRAR TO SIGN THIS CERTIFICATE AND TO FILE IT IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.  
 IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FILE IT IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.



## CERTIFICATE OF DEATH

Reg. Dist. No.

13841

13886

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Petersville</b>		c. LENGTH OF STAY IN 1b <b>X Petersville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. Knoxville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Robert</b> Last <b>Hoar</b>		4. DATE OF DEATH Month <b>12</b> Day <b>3</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-17-1896</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Months <b>6</b> Days <b>4</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MATERIAL DISTRIBUTOR B.&amp;O</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Hoar</b>		14. MOTHER'S MAIDEN NAME <b>Ida Merriman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>World War 1</b>		16. SOCIAL SECURITY NO. <b>Mrs. Olive Hoar, Knoxville, Maryland</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced cerebral arteriosclerosis</b> 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Semiprimary, advanced</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3-18 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-1-1960</b> to <b>12-3-1960</b> that I last saw the deceased alive on <b>12-3-1960</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C.E. Pruitt</b>		ADDRESS (Street, city or town, state) <b>Brunswick Maryland</b>	
PHYSICIAN'S NAME (Type) <b>C.E. Pruitt</b>		DATE SIGNED <b>12-8-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/5/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Saint Marks</b>		22d. LOCATION (City, town, or county) (State) <b>Petersville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Field</b>		ADDRESS <b>Brunswick, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWS. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13887 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13842

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New-Market</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New-Market</u>	
c. LENGTH OF STAY IN 1b <u>15 years</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Lavinia P. Holland</u>		4. DATE OF DEATH <u>December 28 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1888</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. FUND 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William H Pryor</u>		14. MOTHER'S MAIDEN NAME <u>Mary L Hackey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-07-2266</u>	
17. INFORMANT <u>Mary J Beach, New-Market, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 minutes</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>DEC 28, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 30-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SIMPSON CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>NEW MARKET MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lucian K. Fakorn New-Market</u>		24a. REC'D BY REGISTRAR <u>DATE</u> <u>4 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>MALE</u>		3. AGE <u>45</u>	
4. DATE OF DEATH <u>10-15-1968</u>		5. TIME OF DEATH <u>10:00 AM</u>		6. PLACE OF DEATH <u>HOME</u>	
7. OCCUPATION <u>CLERK</u>		8. MARITAL STATUS <u>MARRIED</u>		9. NUMBER OF DEPENDENTS <u>2</u>	
10. CAUSE OF DEATH <u>HEART DISEASE</u>		11. MANNER OF DEATH <u>NATURAL</u>		12. SIGNATURE OF EXAMINER <u>[Signature]</u>	
13. SIGNATURE OF DECEASED <u>[Signature]</u>		14. SIGNATURE OF WITNESS <u>[Signature]</u>		15. SIGNATURE OF PHYSICIAN <u>[Signature]</u>	
16. SIGNATURE OF CORONER <u>[Signature]</u>		17. SIGNATURE OF JURY <u>[Signature]</u>		18. SIGNATURE OF JUDGE <u>[Signature]</u>	
19. SIGNATURE OF DISTRICT ATTORNEY <u>[Signature]</u>		20. SIGNATURE OF CLERK <u>[Signature]</u>		21. SIGNATURE OF RECORDER <u>[Signature]</u>	
22. SIGNATURE OF ARCHIVIST <u>[Signature]</u>		23. SIGNATURE OF REGISTRAR <u>[Signature]</u>		24. SIGNATURE OF CLERK <u>[Signature]</u>	
25. SIGNATURE OF CLERK <u>[Signature]</u>		26. SIGNATURE OF CLERK <u>[Signature]</u>		27. SIGNATURE OF CLERK <u>[Signature]</u>	
28. SIGNATURE OF CLERK <u>[Signature]</u>		29. SIGNATURE OF CLERK <u>[Signature]</u>		30. SIGNATURE OF CLERK <u>[Signature]</u>	
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100. SIGNATURE OF CLERK <u>[Signature]</u>		101. SIGNATURE OF CLERK <u>[Signature]</u>		102. SIGNATURE OF CLERK <u>[Signature]</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13888  
13843  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adamstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adamstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>EDWARD</b> Last <b>KANODE</b>		4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 July 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Park Mills, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles E. Kanode</b>		14. MOTHER'S MAIDEN NAME <b>Hester Zimmerman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Carrie V. Kanode (Same as item #1)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO (b) <b>Arterio-sclerotic heart dis.</b> DUE TO (c) <b>10+ yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1947</b> to <b>Dec 20</b> , that (I) (we) last saw the deceased alive on <b>20 Dec 1960</b> and that death occurred at <b>5 A</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>Charles H. Conley, Jr.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>28 Dec 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr., M.D.</b>		22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-30-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 30 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

1928

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

NEW YORK

DEATH

CERTIFICATE

OF DEATH

IN THE

STATE OF

NEW YORK

DEPARTMENT OF

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DEPARTMENT OF

HEALTH

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DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
13889									
13844									
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville rural					c. LENGTH OF STAY IN 1b Lifetime				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Jacob Henry Kauffman					4. DATE OF DEATH Month Day Year December 9 19 60				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 24, 1882		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lime Burner		10b. KIND OF BUSINESS OR INDUSTRY F.R. Lime Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob Kauffman					14. MOTHER'S MAIDEN NAME Elizabeth Starner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Daisy I. Kauffman Walkersville RD1					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 33 1 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from July 1957, to Dec. 9, 1960, that (I) (we) last saw the deceased alive on Dec. 6, 1960, and that death occurred at 7:45 PM, from the causes and on the date stated above. 22a. SIGNATURE E. A. Dettbarn 22c. PHYSICIAN'S NAME (Type) E. A. Dettbarn 22b. DATE SIGNED Dec. 10/60 22d. ADDRESS Walkersville, Maryland 23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE THEREOF 12-12-60 23c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery 23d. LOCATION (City, town, or county) (State) Lewistown, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Creager ADDRESS Thurmont, Md. 25a. REC'D BY REGISTRAR DATE DEC 13 '60 25b. REGISTRAR'S SIGNATURE									

1930

CERTIFICATE OF DEATH

13883

Decedent's Name: Robert L. Williams Date of Birth: May 15, 1892

Place of Birth: Waverly, Maryland Date of Death: Oct. 21, 1930

Age at Death: 38 Sex: Male Race: White

Occupation: Farmer Cause of Death: Heart Disease

U.S.A. U.S.A. U.S.A. U.S.A.

Signature of Physician: Elisabeth Warner

Signature of Coroner: James L. Williams

Signature of Registrar: Mrs. Daisy L. Williams

Signature of Burial: Waverly, Maryland

Signature of Burial: Waverly, Maryland

Signature of Burial: Waverly, Maryland

Signature of Burial: Waverly, Maryland

Signature of Burial: Waverly, Maryland

Signature of Burial: Waverly, Maryland

Signature of Burial: Waverly, Maryland

Signature of Burial: Waverly, Maryland

Signature of Burial: Waverly, Maryland

Signature of Burial: Waverly, Maryland

Signature of Burial: Waverly, Maryland

Signature of Burial: Waverly, Maryland

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13845

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>18 College Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Julie Lynn Kennedy</u>		4. DATE OF DEATH Month Day Year <u>December 16 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 15, 1960</u>
9. AGE (In years lost birthday) yrs. <u>15</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>15 33</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Richard Linwood Kennedy</u>		14. MOTHER'S MAIDEN NAME <u>CAROL ANN Fagan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Premature separation of placenta</u> DUE TO (c) <u>2 days?</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 15</u> 19 <u>60</u> to <u>Dec. 16</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Dec 15</u> 19 <u>60</u> , and that death occurred at <u>5:45 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard O. Thomas Jr.</u>		22b. DATE SIGNED <u>12/16/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bernard O. Thomas, M. D.</u>		22d. ADDRESS <u>Frederick, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-17-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

1347

DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK  
CERTIFICATE OF DEATH

1347

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of attending physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Signature of informant: \_\_\_\_\_

Printed name of informant: \_\_\_\_\_

Address of informant: \_\_\_\_\_

City and State: \_\_\_\_\_

Signature of informant: \_\_\_\_\_

13873

13846

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 South Maryland Avenue</b>				d. STREET ADDRESS <b>8 South Maryland Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Burton Langley</b>				4. DATE OF DEATH Month Day Year <b>12 25 1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>8-14-1905</b>		9. AGE (In years lost birthday) yrs. <b>55</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John T. Langley</b>				14. MOTHER'S MAIDEN NAME <b>Leona House</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Mrs. Maxine Langley, Brunswick, Md.</b>				
1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>224X</b> DUE TO <b>Rathke's pouch cyst.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>8-14-1905</b> DUE TO <b>8-14-1905</b> (c) <b>8-14-1905</b>								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>7-1-1960</b> , to <b>12-25-1960</b> , that I lost saw the deceased alive on <b>12-15-1960</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brunswick, Md</b> DATE SIGNED <b>12-27-60</b> ACTUAL SIGNATURE <b>C.E. Pruitt</b> M.D. <b>Brunswick, Md</b> PHYSICIAN'S NAME (Type) <b>C.E. Pruitt</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-28-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union</b>		22d. LOCATION (City, town, or county) (State) <b>LOVETTSVILLE, VIRGINIA</b> <b>Lovettsville</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bill Felt</b> <b>Brunswick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Orlino S. Hand</b>		

VS A15 (4)  
15M 9/5B

VS A15 (4)  
15M 9/5B

1884

CERTIFICATE OF DEATH

1884

Blank form with faint lines and text, including a signature at the bottom.



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13890

13847

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown-Rural</b>				c. LENGTH OF STAY IN 1b <b>3 Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Market</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley View Nursing Home</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>IRVING</b> Last <b>LIPPY</b>				4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>31 Oct 1878</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR: Months <b>82</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Owner of Business</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Michael Lippy</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>217-32-7186</b>		17. INFORMANT <b>Miss E. Louise Lippy, 600-4 Taney Ave., Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> DUE TO <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 1966</b> to <b>12/16 1960</b> , that (I) (we) last saw the deceased alive on <b>12/15 1960</b> , and that death occurred at <b>12:05 A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>James B. Thomas</b>				22b. DATE SIGNED <b>16 Dec 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>James B. Thomas, M. D.</b>				22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-17-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 19 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

13880

CERTIFICATE OF DEATH



13880

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESS: [illegible]

SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESS: [illegible]

SIGNATURE OF DECEASED: [illegible]



DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESS: [illegible]

SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESS: [illegible]

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13858

13848

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>221 East Patrick Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>M.</b> Last <b>MacDOUGAL</b>				4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 March 1887</b>		9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Trainmen</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Shelbyville, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alexander MacDougal</b>				14. MOTHER'S MAIDEN NAME <b>Floretta Hobbs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Gladys James MacDougal (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Infarction of right basal ganglia of aortic aneurysm</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 15, 1956</b> , to <b>Dec 27, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 27, 1960</b> , and that death occurred at <b>6 P.M.</b> , from the causes and on the date stated above.							
22c. SIGNATURE <b>Henry V. Chase</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>28 Dec 1960</b>	
22a. PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M.D.</b>				22d. ADDRESS <b>4 E. Church St., Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-30-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 30 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

CERTIFICATE OF DEATH

12448

Residence

Age

Occupation

Residence

Residence

Residence

Residence

Residence

Residence

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13859

13849

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>4 Hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FREDERICK</b> Last <b>MASSER</b>				4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12 Oct 1871</b>	
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>			
13. FATHER'S NAME <b>Frederick Masser</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Klipp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-18-7712</b>		17. INFORMANT <b>Mr. Paul G. Masser, RD#4, Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion</b> DUE TO (b) <b>minutes</b> DUE TO (c) <b>minutes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>minutes</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 1960</b> to <b>Dec 15 1960</b> that (I) (we) last saw the deceased alive on <b>Dec 15 1960</b> and that death occurred at <b>8:30 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>B. O. Thomas</b>				22b. DATE <b>19 Dec 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>				22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-19-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 21 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

CERTIFICATE OF DEATH

1925



MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CITY OF BOSTON

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]  
DATE: [illegible]





may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
13860  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13850

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>2 Weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. STREET ADDRESS <b>Shookstown Road</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM AUGUSTUS MASSER</b>				4. DATE OF DEATH Month Day Year <b>December 12, 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4 Aug 1876</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Shookstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick Masser</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Klipp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-5278</b>		17. INFORMANT <b>323 Braddock Ave., Frederick, Md.</b> <b>Frederick W. Masser, Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 yrs +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/8</b> 19 <b>60</b> to <b>12/12</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/12</b> 19 <b>60</b> , and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Henry V Chase</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>14 Dec 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M. D.</b>				22d. ADDRESS <b>4 E. Church St., Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-15-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rocky Springs Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick County Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>DEC 15 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Farris</b>			

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13880

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

13880

Name of Deceased		Sex		Age	
John J. Smith		Male		45	
Residence		Occupation		Cause of Death	
Boston, Mass.		Teacher		Heart Disease	
Date of Death		Place of Death		Time of Death	
Aug 15, 1915		Home		10:30 AM	
Physician		Burial		Interment	
Dr. J. B. Jones		St. Paul's Church		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Minister	

*John J. Smith*  
*Teacher*  
*Boston, Mass.*  
*Aug 15, 1915*  
*Heart Disease*  
*10:30 AM*  
*St. Paul's Church*  
*Cemetery*  
*Dr. J. B. Jones*  
*St. Paul's Church*  
*Cemetery*

1  
Page 4  
TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13851

13891

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sabillasville</b>		c. LENGTH OF STAY IN 1b <b>20 yr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Osba Grover McAfee</b>		4. DATE OF DEATH <b>December 5 19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1893</b>
9. AGE (In years last birthday) <b>67</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>On farms</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Jefferson McAfee</b>		14. MOTHER'S MAIDEN NAME <b>Annie Duncan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWL</b>	
17. INFORMANT <b>Mrs. Alta W. McAfee</b>		Address <b>Sabillasville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease Arteriosclerotic type</b> 965X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Emphysema</b> DUE TO (c) <b>Mustard gas poisoning - bronchial tubes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>30 yrs.</b> <b>4 2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1958</b> to <b>Dec 5 1960</b> that (I) <del>last</del> saw the deceased alive on <b>Nov 5 1960</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James K. Gray</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>James K. Gray</b>		22d. ADDRESS <b>Thurmont, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-8-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Bethel Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>nr. Garfield, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Brager</b>		25a. REC'D BY REGISTRAR <b>DEC 9 '60</b>	
ADDRESS <b>Thurmont, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

13891

Frederick

Sebillville

in home

John

white

laborer

Jefferson

Yes

No

Mrs. Allen W. McAllister

Annie Johnson

Mo.

1884

July 11, 1884

John

December 2

Sebillville

Maryland

Frederick

12-8-80

Dr. Robert C. McAllister

Mo.

James E. Gray

Frederick, Maryland

Frederick, Mo.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13852

FOR STATE  
HEALTH DEPT.

13892

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg RD 3</u> c. LENGTH OF STAY IN 1b <u>7 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg RD 3</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles Luther McClain</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>December 16</u> 19 <u>60</u> Month Day Year		
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept. 26 1908</u>	<b>9. AGE</b> (In years last birthday) <u>51</u> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Motor Express</u>		
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Fairfield #1 Penna</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Clarence M. McClain</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Riley</u>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>Yes Army 24.12.21-14-09-2995</u>			<b>16. SOCIAL SECURITY NO.</b> <u>214-09-2995</u>		
<b>17. INFORMANT</b> <u>Mrs Dorothy McClain</u> Address _____					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></b>					
<b>ACTUAL SIGNATURE</b> <u>B. D. Thomas</u>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> DATE SIGNED _____ <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>Dec. 16, 1960</u>		
<b>EXAMINER'S NAME (Type)</b> <u>B. D. Thomas, M.D.</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>12/16/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Fairfield</u>	
<b>22d. LOCATION (City, town, or county)</b> <u>Fairfield</u>		<b>(State)</b> <u>Penna.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter J. Grove</u> ADDRESS <u>Waynesboro, Penna.</u>			<b>24a. REC'D BY REGISTRAR</b> DATE <u>DEC 19 '60</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frause</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13893

13853

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont Rural</b>		c. LENGTH OF STAY IN 1b <b>40 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HATTIE</b> First <b>JOSAPHINE</b> Middle <b>MILLER</b> Last		4. DATE OF DEATH <b>Dec. 31. 1960</b> Month <b>Dec.</b> Day <b>31</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5. 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Thomas Obrein</b>		14. MOTHER'S MAIDEN NAME <b>Harriette MESSER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Henry Miller Thurmont</b>		Address <b>R.D. 2 MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis -</b> <b>332X</b> DUE TO <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 26 - 1960</b> to <b>Dec. 31, 19</b> , that (I) (we) last saw the deceased alive on <b>Dec. 31 - 1960</b> , and that death occurred at <b>PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James K. Gray</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>James K. Gray</b>		22d. ADDRESS <b>Thurmont. MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Jan. 3. 1961</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Thurmont, Fredk. Co MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Crager</b>		25a. REC'D BY REGISTRAR <b>JAN 4 '61</b>	
ADDRESS <b>Thurmont. MD</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

13883

CENTRAL AVE OF DEATH

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13854

13894

Item 9 Film 277 12-27-60 et

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick rural</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Morningstar</b>		4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1896</b>
9. AGE (In years, months, days) <b>74 64</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b> Hours <b>64</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Morningstar</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Steiner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>233-05-4598</b>	
17. INFORMANT <b>Mrs. Helen T. Morningstar</b>		Address <b>Frederick</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro VASCULAR ACCIDENT -</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic bronchitis &amp; emphysema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> 19 <b>60</b> , to <b>12</b> 19 <b>60</b> , that (II) (we) lost the deceased alive on <b>12/13</b> 19 <b>60</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard C. Reynolds,</b>		22b. DATE SIGNED <b>12/15/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Richard C. Reynolds</b>		22d. ADDRESS <b>9 E. Church St. Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-18-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glade Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Walkersville Fredk. Co. Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Cragg</b>		25a. REC'D BY REGISTRAR <b>DEC 20 '60</b>	
ADDRESS <b>Thurmont, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>	

3 RD

13884

DEPARTMENT OF HEALTH

Frederick

Maryland

Frederick

Frederick

MD

Frederick

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December 1

John Henry Montgomery

x

male white

born 12, 1890

County

Frederick

Frederick

Frederick

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1911

12-1-11

Frederick

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13874

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13855

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> 35		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>B. &amp; O. R.R. East bound hump</b>			d. STREET ADDRESS <b>110 East "A" Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Carlton</b> Middle <b>—</b> Last <b>New</b>			4. DATE OF DEATH Month <b>12</b> Day <b>20</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-4-1918</b>		9. AGE (In years last birthday) <b>42</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R.R. Co</b>	11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James New</b>			14. MOTHER'S MAIDEN NAME <b>Eula Bell</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>World 11</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs. Frances New, Brunswick, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorage caused by multiabie fractures</b> <b>800X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>While braking freight car on R.R. B &amp; O - fell under the car</b>			
20c. TIME OF INJURY Month, Day, Year <b>7:30</b> Hour <b>X</b> p. m. <b>12/22</b> <b>1960</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>B &amp; O RR yard</b>	20f. (City or town) <b>Brunswick</b>	(County) <b>Fred.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12-21-1960</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-23-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Saint Marks</b>		22d. LOCATION (City, town, or county) (State) <b>Petersville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Galt</b>		ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 27 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1952

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1952

NAME OF DECEASED: [REDACTED]

DATE OF DEATH: [REDACTED]

PLACE OF DEATH: [REDACTED]

AGE: [REDACTED]

SEX: [REDACTED]

RACE: [REDACTED]

EDUCATION: [REDACTED]

OCCUPATION: [REDACTED]

CAUSE OF DEATH: [REDACTED]

MANNER OF DEATH: [REDACTED]

DISPOSITION OF BODY: [REDACTED]

DATE OF INTERVIEW: [REDACTED]

NAME OF EXAMINER: [REDACTED]

SIGNATURE OF EXAMINER: [REDACTED]

DATE OF SIGNATURE: [REDACTED]

NAME OF REGISTRAR: [REDACTED]

SIGNATURE OF REGISTRAR: [REDACTED]

DATE OF SIGNATURE: [REDACTED]

NAME OF CLERK: [REDACTED]

SIGNATURE OF CLERK: [REDACTED]

DATE OF SIGNATURE: [REDACTED]



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
13861  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13856  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>11</b> Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13 East Ninth Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>NULL</b>		4. DATE OF DEATH Month <b>December</b> Day <b>29</b> , Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1891</b>
9. AGE (In years last birthday) yrs. <b>69</b>		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>29</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auctioneer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William C. Null</b>		14. MOTHER'S MAIDEN NAME <b>Frances Cutsail</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-0008</b>	
17. INFORMANT <b>Mrs. Luma A. Null-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis with</b> DUE TO (c) <b>1445.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour.</b> <b>14 years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recurrent Ischemic ulcer</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/19</b> 19 <b>60</b> to <b>12/29</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>12/7</b> 19 <b>60</b> , and that death occurred at <b>7:30P</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L R Schoolman</b>		22b. DATE <b>12/31/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Louis R. Schoolman, M. D.</b>		22d. ADDRESS <b>Professional Building, Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/2/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 4 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

1885

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1885

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "and" and "the" are visible.]*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13862

CERTIFICATE OF DEATH

13857

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>606 Charles Street</b>				d. STREET ADDRESS <b>606 Charles Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MELVIN</b> Middle <b>ROY</b> Last <b>NUSZ, SR.</b>				4. DATE OF DEATH Month <b>December</b> Day <b>8</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>13 March 1904</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min.		IF UNDER 24 HRS. Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Company</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Elmer Nusz</b>				14. MOTHER'S MAIDEN NAME <b>Clara Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-10-2689</b>		17. INFORMANT <b>Mrs. Bertha Nusz (Same as item #1)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> (c) <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>20410.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Frederick</b>				20g. (County) <b>Frederick</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1930</b> to <b>Dec 8</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Dec 8</b> 19 <b>60</b> , and that death occurred at <b>7:30P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>H. F. Kline</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10 Dec 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. F. Kline, M. D.</b>				22d. ADDRESS <b>7 N. Market St., Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-11-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS <b>Frederick, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 12 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13858

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>		c. LENGTH OF STAY IN 1b <b>5 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>320 Waverly Terrace</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>William</b> Last <b>Orndorff</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22, 1921</b>
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR: Months <b>39</b> Days <b>39</b> Hours <b>39</b> Min. <b>39</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>roofer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>roofing</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Orndorff</b>		14. MOTHER'S MAIDEN NAME <b>Flossie Welsh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>World war II</b>		16. SOCIAL SECURITY NO. <b>220-10-0655</b>	
17. INFORMANT <b>Mrs. Flossie Hudson</b>		Address <b>351 Balto, Ave., Md. Cumberland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced bilateral pulmonary tuberculosis</b> DUE TO <b>002</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>002X</b> (b) <b>4 years</b> (c) <b>4 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-15-60</b> 19 to <b>12-21-60</b> 19, that (I) (we) last saw the deceased alive on <b>12-21-60</b> 19, and that death occurred at <b>9.45 pm</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Michael G. Zavis</b>		22b. DATE SIGNED <b>12-21-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Michael G. Zavis</b>		22d. ADDRESS <b>Cullen, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/26/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bald Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hazen Rd. Bedford Co. Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Bragan</b>		ADDRESS <b>Thurmont Md</b>	
25a. REC'D BY REGISTRAR <b>DEC 27 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

13870

CERTIFICATE OF DEATH

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13896

## CERTIFICATE OF DEATH

Reg. Dist. No.

13859

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>FREDERICK</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ward 200 WR 64</u>				d. STREET ADDRESS <u>X Point of Rocks</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Terri Lee Pearl</u>				4. DATE OF DEATH Month Day Year <u>December 19 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 June 60</u>	9. AGE (In years last birthday) yrs. <u>6</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Eugene F. Pearl</u>				14. MOTHER'S MAIDEN NAME <u>MARY M. MCKELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bacterial Meningitis</u> <u>340.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemophilus influenza</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>18-24 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>17 Dec.</u> , 19 <u>60</u> , to <u>19 Dec.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>19 Dec.</u> , 19 <u>60</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James W. Bass</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>19 Dec 60</u>			
PHYSICIAN'S NAME (Type) <u>James W. Bass</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>		22d. LOCATION (City, town, or county) (State) <u>JEFFERSON MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Lee Fuchs</u>				ADDRESS <u>BRUNSWICK, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur P. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13875

CERTIFICATE OF DEATH

Reg. Dist. No. 13860

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				c. LENGTH OF STAY IN 1b <b>35 B runswick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7 North Maple Avenue</b>				d. STREET ADDRESS <b>7 North Maple Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>William</b> Last <b>Rau</b>				4. DATE OF DEATH Month <b>12</b> Day <b>31</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-22-1894</b>		9. AGE (In years last birthday) yrs. <b>66</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Retired Yard Foreman B.&amp;.O.R.R.Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William O. Rau</b>				14. MOTHER'S MAIDEN NAME <b>Mary Agnes Conway</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		INFORMANT Address <b>Mrs. Marie Rau, Brunswick, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Coromary Insufficiency</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>3 min.</b> <b>1 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 28, 1960</b> to <b>Dec. 31, 1960</b> that I last saw the deceased alive on <b>Dec. 31, 1960</b> , and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>15 S. Maryland Ave. 1-3-61</b> DATE SIGNED							
ACTUAL SIGNATURE <b>C.T. Byron Kao</b>		M.D. <b>15 S. Maryland Ave. 1-3-61</b>					
PHYSICIAN'S NAME (Type) <b>C.T. Byron Kao, M.D.</b>		<b>Brunswick, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-3-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Saint Peters</b>		22d. LOCATION (City, town, or county) (State) <b>Harpers Ferry W. Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. E. Felt</b>				ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 5 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles L. Kinner</b>			

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13863  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13861  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>11 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>215 East Fifth Street</b>				e. STREET ADDRESS <b>215 East Fifth Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>W.</b> Last <b>RENNER</b>				4. DATE OF DEATH Month <b>December</b> Day <b>8,</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 Dec 1861</b>	9. AGE (In years last birthday) <b>98</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elias Renner</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Dusing</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Franklin C. McCanner (Same as item #1)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Chemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular disease</b> DUE TO (c) <b>5 days</b> <b>5 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1945</b> to <b>Dec 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec 17, 1960</b> , and that death occurred at <b>11 A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>B O Thomas</b>				22b. DATE SIGNED <b>10 Dec 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>				22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-10-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etnison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 12 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

12281

MARYLAND AND DEPARTMENT OF HEALTH  
OFFICE OF VITAL RECORDS AND STATISTICS  
CERTIFICATE OF DEATH

12281

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
John Doe		Male		45		Jan 1, 1920		New York City		Jan 15, 1965		New York City		Heart Disease		Natural		J. Doe, M.D.		J. Doe, Registrar		Jan 15, 1965	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

13864

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13862

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>DOA Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>505 Fleming Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>WALTER</b> Last <b>RIDGELY</b>				4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>28 June 1890</b>		9. AGE (In years last birthday) <b>70</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign county) <b>Frederick, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Charles G. Ridgely</b>				14. MOTHER'S MAIDEN NAME <b>Ellen M. Stull</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-12-0625</b>		17. INFORMANT <b>Mrs. Margaret Ridgely (Same as item #2)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis of coronary vessels</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>10 yrs</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1954</b> to <b>Dec. 18, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 17, 1960</b> , and that death occurred at <b>8:30P</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Henry V. Chase</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>20 Dec 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M. D.</b>				22d. ADDRESS <b>4 D. Church St., Frederick, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-21-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>DEC 23 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

100-100

MARYLAND STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS  
Baltimore, Maryland  
CERTIFICATE OF DEATH

1988

Dec 10, 1988

Dec 10, 1988

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Dec 10, 1988

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove part 3 papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13863  
CERTIFICATE OF DEATH

13863

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>		e. STREET ADDRESS <b>Hill street</b>	
3. NAME OF DECEASED (Type or print) First <b>MATTIE</b> Middle <b>W.</b> Last <b>RUNKLES</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-3-1894</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Henry Wilson</b>		16. MOTHER'S MAIDEN NAME <b>Martha L. Watkins</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <b>none</b>	
19. INFORMANT <b>Henry P. Runkles. Mt. Airy, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Gastro-intestinal Hemorrhage</b> DUE TO <b>Cause Undetermined</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>3 days</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardio-vascular Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>— 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-21-</b> 1960, to <b>12-24-</b> 1960, that (I) (we) last saw the deceased alive on <b>12-24-</b> 1960, and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>A. A. Pearre</b>		22b. DATE SIGNED <b>12/24/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. A. PEARRE</b>		22d. ADDRESS <b>Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-26-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prospect</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		25a. REC'D BY REGISTRAR <b>DEC 27 '60</b>	
ADDRESS <b>Winfield, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13864

13897

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. 1 LeGore Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. 1 LeGore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jacob Hoffman Saylor</u>		4. DATE OF DEATH Month Day Year <u>12 26 19 60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7. 1902</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>S. Albert Saylor</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hoffman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>113-30-3644</u>	
17. INFORMANT <u>Mrs Angie Myers</u>		Address <u>Westminster Md. D. F. D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE-(a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12.29. 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Pipe Creek</u> 22d. LOCATION (City, town, or county) (State) <u>Near Uniontown Md.</u> 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Raymond F. Wright Union Bridge, Md.</u> 24a. REC'D BY REGISTRAR DATE <u>JAN 3. 61</u> 24b. REGISTRAR'S SIGNATURE <u>James S. Thayer</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE		22. SIGNATURE OF DEPUTY CONSTABLE		23. SIGNATURE OF TOWNSHIP CLERK		24. SIGNATURE OF COUNTY CLERK	
25. SIGNATURE OF STATE CLERK		26. SIGNATURE OF STATE DEPARTMENT OF HEALTH		27. SIGNATURE OF STATE DEPARTMENT OF HEALTH		28. SIGNATURE OF STATE DEPARTMENT OF HEALTH		29. SIGNATURE OF STATE DEPARTMENT OF HEALTH		30. SIGNATURE OF STATE DEPARTMENT OF HEALTH	

TO BE FILLED BY PHYSICIAN OR OTHER PERSON QUALIFIED TO FURNISH INFORMATION CONCERNING THE DEATH OF THE DECEASED.

1. NAME OF DECEASED: [Faint text]

2. SEX: [Faint text]

3. AGE: [Faint text]

4. RACE: [Faint text]

5. DATE OF BIRTH: [Faint text]

6. PLACE OF BIRTH: [Faint text]

7. DATE OF DEATH: [Faint text]

8. TIME OF DEATH: [Faint text]

9. PLACE OF DEATH: [Faint text]

10. CAUSE OF DEATH: [Faint text]

11. MANNER OF DEATH: [Faint text]

12. SIGNATURE OF EXAMINER: [Faint text]

13. SIGNATURE OF WITNESS: [Faint text]

14. SIGNATURE OF PHYSICIAN: [Faint text]

15. SIGNATURE OF CORONER: [Faint text]

16. SIGNATURE OF JURY: [Faint text]

17. SIGNATURE OF JUDGE: [Faint text]

18. SIGNATURE OF CLERK: [Faint text]

19. SIGNATURE OF SHERIFF: [Faint text]

20. SIGNATURE OF DEPUTY SHERIFF: [Faint text]

21. SIGNATURE OF CONSTABLE: [Faint text]

22. SIGNATURE OF DEPUTY CONSTABLE: [Faint text]

23. SIGNATURE OF TOWNSHIP CLERK: [Faint text]

24. SIGNATURE OF COUNTY CLERK: [Faint text]

25. SIGNATURE OF STATE CLERK: [Faint text]

26. SIGNATURE OF STATE DEPARTMENT OF HEALTH: [Faint text]

27. SIGNATURE OF STATE DEPARTMENT OF HEALTH: [Faint text]

28. SIGNATURE OF STATE DEPARTMENT OF HEALTH: [Faint text]

29. SIGNATURE OF STATE DEPARTMENT OF HEALTH: [Faint text]

30. SIGNATURE OF STATE DEPARTMENT OF HEALTH: [Faint text]



TO HOSPITAL (If attending physician: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
13866  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13865

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>FREDERICK Route # 3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLINTON</b> Middle <b>M</b> Last <b>SCHWARTZ</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>25</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-13-1890</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL SCHWARTZ</b>		14. MOTHER'S MAIDEN NAME <b>ALICE BOYER Peters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-34-1122</b>	
17. INFORMANT <b>Bulah Mrs. B. Schwartz</b>		Address <b>Rt. # 3 Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>490X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9</b> <b>1940</b> to <b>12-25</b> , 1960, that (I) (we) last saw the deceased alive on <b>12-25</b> , 1960, and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>B. O. Thomas</b>		22b. DATE SIGNED <b>DEC 25, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. O. Thomas, MD</b>		22d. ADDRESS <b>Frederick, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-28-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Gileff</b>		25a. REC'D BY REGISTRAR <b>DEC 29 '60</b>	
ADDRESS <b>Frederick, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>	

CERTIFICATE OF DEATH

1928



CHIEF OF BUREAU

DEPARTMENT OF HEALTH

1928-1929

DEPARTMENT OF HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13867 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13866

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN life <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>207 East Second Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>AUSTIN</b> Last <b>SHERALD</b>		4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Aug 1919</b>
9. AGE (In years last birthday) <b>41</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>	11. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Allen F. Sherald, Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth M. Sullivan</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>	
16. SOCIAL SECURITY NO. <b>212-14-7107</b>		17. INFORMANT <b>Mrs. Betty L. Sherald</b> Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>13 Dec 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-15-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 15 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

WYOMING MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF _____ CITY OF _____		DECEASED NAME _____ SEX _____ AGE _____ OCCUPATION _____ RESIDENCE _____ PLACE OF BIRTH _____ DATE OF BIRTH _____ DATE OF DEATH _____ TIME OF DEATH _____ PLACE OF DEATH _____ CAUSE OF DEATH _____ MANNER OF DEATH _____ MEDICAL HISTORY _____ SOCIAL HISTORY _____ FAMILY HISTORY _____ PHYSICAL EXAMINATION _____ LABORATORY EXAMINATIONS _____ POSTMORTEM EXAMINATION _____ SIGNATURE OF EXAMINER _____ TITLE OF EXAMINER _____ DATE OF EXAMINATION _____	
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## CERTIFICATE OF DEATH

Reg. Dist. No. 13867

13898

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick R 7</i>				c. LENGTH OF STAY IN 1b <i>367 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Co. Chronic Hosp.</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mourona</i>			
d. STREET ADDRESS <i>1</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>GEORGE WILLIAM SHOEMAKER</i>				4. DATE OF DEATH Month Day Year <i>Dec 28 1960</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 19 1868</i>	
9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Freight Transfer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>James Samuel Shoemaker</i>				14. MOTHER'S MAIDEN NAME <i>Mary Ellen Orrison</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>219-14-9934A</i>			
17. INFORMANT <i>Mr. Ernest Shoemaker, Walkersville, RI, Md</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>2 yrs.</i> (c) <i>2 yrs.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Dec 17</i> , 19 <i>60</i> , to <i>Dec 28</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Dec 27</i> , 19 <i>60</i> , and that death occurred at <i>7:55 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>771 Market St Frederick Md</i> DATE SIGNED <i>Dec 29 1960</i>							
ACTUAL SIGNATURE <i>H.F. Kline</i>				M.D. <i>Frederick Md.</i>			
PHYSICIAN'S NAME (Type) <i>H.F. KLINE M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/31/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Paul's Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Point of Rocks Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Barton, Walkersville, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JAN 3 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.



**1**

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

13868

13868

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural RD#6</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>		d. STREET ADDRESS <u>Linganore Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BARBARA</u> Middle <u>JEAN</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 6, 1960</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rolph Lorraine Smith</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Boyen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Mother</u>		Address <u>                    </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>                    </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>                    </u> DUE TO <u>                    </u> (c) <u>Immaturity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 dys</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>                    </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6 Dec 1960</u> to <u>9 Dec 1960</u> , that (I) (we) last saw the deceased alive on <u>8 Dec 1960</u> , and that death occurred at <u>7:45 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R L Guest</u>		22b. DATE SIGNED <u>                    </u>	
22c. PHYSICIAN'S NAME (Type) <u>R. L. Guest, M. D.</u>		22d. ADDRESS <u>66.3rd St. Frederick, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-10-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 12 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2069162XV2

CERTIFICATE OF HEALTH

1944

W. J. Jones

W. J. Jones

Physician - Rural 1944

Signature of

CAP. S. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

W. J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
13878  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13869

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Minia D. Smith</b>		4. DATE OF DEATH Month Day Year <b>Dec. 3 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1874</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Firor</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Lightner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Lillian Smith</b>		Address <b>Thurmont, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease - Arteriosclerotic Type</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis - severe</b> DUE TO (c) <b>Post-paralytic general enfeeblement</b> 2 years.		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>2 years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post-paralytic general enfeeblement</b> 2 years.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.) <b>no</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 5 1957</b> to <b>Dec 3 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov 30 1960</b> and that death occurred at <b>8 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James K. Gray</b>		22b. DATE SIGNED <b>DEC 8 '60</b>	
22c. PHYSICIAN'S NAME (Type) <b>James K. Gray</b>		22d. ADDRESS <b>Thurmont, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-6-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Cragg</b>		25a. REC'D BY REGISTRAR <b>DEC 8 '60</b>	
ADDRESS <b>Thurmont, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

13876

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13870

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brunswick</i> c. LENGTH OF STAY IN 1b <i>Life</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Center Avenue</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brunswick</i> d. STREET ADDRESS <i>Central Avenue</i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John William Spriggs</i>		4. DATE OF DEATH Month <i>12</i> Day <i>16</i> Year <i>1960</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>4-7-1897</i>		9. AGE (In years last birthday) <i>63</i> yrs.		10. IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William Spriggs</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Hunter</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Junie Lipscomb Brunswick Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>			
20c. TIME OF INJURY Month, Day, Year Hour <i></i> a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	
20f. (City or town) <i></i> (County) <i></i> (State) <i></i>		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>12/16/60</i>	
EXAMINER'S NAME (Type) <i>B. O. THOMAS</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-19-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mountains</i>	
22d. LOCATION (City, town, or county) <i>Brunswick, Maryland</i>		(State) <i></i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. H. Felt</i>		ADDRESS <i>Brunswick Md</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 23 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Finner</i>					





VR A15 (4)  
ISM 9/59

10

# IN THE CIRCUIT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

1933

Proctor

Maryland

Proctor

Proctor

Thompson

22 Nov.

Proctor

x

MD 2

100

Dec. 2

David Stand

Galvin

June 20, 1932

x

white

male

U.S.A.

Maryland

Proctor

Proctor

Cassandra Stanton

David Stand

Alfred Stand Thompson, Jr.

Nov.

No.

Thompson, Md.

James L. Gray

near Washington, Md.

Handy's Cemetery

12-2-60

Proctor

Thompson, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13872

13869

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK,</b>		c. LENGTH OF STAY IN 1b <b>Four days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4 days / FREDERICK,</b>		d. STREET ADDRESS <b>1 FREDERICK Maryland.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALEX</b> Middle <b>ROSCOE</b> Last <b>STROUP</b>		4. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 13, 1879</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinoise</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM D. STROUP</b>		14. MOTHER'S MAIDEN NAME <b>MARY WILSON STROUP</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W. One</b>		16. SOCIAL SECURITY NO. <b>515-09-1956</b>	
17. INFORMANT <b>Mrs. Sarah C. Stroup,</b>		Address <b>95, Stewart Manor Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Volulus of large bowel</b> 570-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive HEART DISEASE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/15</b> , 19 <b>60</b> , to <b>12/17</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/14</b> , 19 <b>60</b> , and that death occurred at <b>9<sup>00</sup> A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard E. Reynolds,</b>		ADDRESS (Street, city or town, state) <b>9 E. Church St. Fred Md.</b> DATE SIGNED <b>12/17/60</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD C. REYNOLDS</b>		M.D. <b>9 E. Church St. Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/20/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DAILEY'S FUNERAL HOME</b>		ADDRESS <b>FREDERICK, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE DEC 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Howard</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 13873

13900

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>				c. LENGTH OF STAY IN 1b <b>1 yr. 3 Mon.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ijamsville P.O.</b>				d. STREET ADDRESS <b>Ijamsville P.O.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ossie</b> Middle <b>Thompson</b> Last <b>Thompson</b>				4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 21-1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>		IF UNDER 24 HRS. Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George Young</b>				14. MOTHER'S MAIDEN NAME <b>Nannie Hawkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-26-2120</b>			
17. INFORMANT <b>Roland Thompson-122 W. All Saints</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio coronary occlusion</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart Disease</b> DUE TO (c) <b>20 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 59</b> , to <b>Dec. 21, 1960</b> , that I last saw the deceased alive on <b>Dec. 27, 1960</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Rafel L. Under</b> M.D.							
PHYSICIAN'S NAME (Type) <b>R. L. MICHELS</b>				Shopping Center Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Jan. 4-61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Ebernaezer</b>				22d. LOCATION (City, town, or county) (State) <b>Frederick Co. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks 111</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 6 '61</b>			
ADDRESS <b>Frederick, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

13300

13313

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of death: *Jan 15 1945*  
5. Place of death: *Home*  
6. Cause of death: *Heart disease*  
7. Signature of physician: *J. Smith*  
8. Signature of registrar: *A. Jones*  
9. Date of registration: *Jan 16 1945*  
10. Place of registration: *City Hall*



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13874

13901

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont R.F.D.I	c. LENGTH OF STAY IN lb I 1/2 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont R.F.D.I	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Mae Toms		4. DATE OF DEATH Month Day Year December 19 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec, 15, 1924
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Kinney		14. MOTHER'S MAIDEN NAME Belva Baughter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Wilber Toms, Thurmont R.F.D.I		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Third degree burnes 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Clothes and bedding caught fire	
20c. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> p.m. 12/19/60	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) Md. (State) Thurmont R.D.I, Frederick
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 20, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/24/60	22c. NAME OF CEMETERY OR CREMATORY Bethel	22d. LOCATION (City, town, or county) (State) Folville Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Barton, Walkersville, Md.		24a. REC'D BY REGISTRAR DATE DEC 23 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13875

13902

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg rural</b>		c. LENGTH OF STAY IN 1b <b>13 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg rural</b>		d. STREET ADDRESS <b>Own Home</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Kenneth</b> Middle <b>Robert</b> Last <b>Wagaman</b>		4. DATE OF DEATH Month <b>December</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1914</b>
9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>14</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sanitarian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Health Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard Wagaman</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Harbaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>202-07-4917</b>	
17. INFORMANT <b>Carolyn B. Wagaman</b>		Address <b>Emmitsburg RD 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>arteriosclerotic C.V. disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic C.V. disease</b> (c) <b>arteriosclerotic C.V. disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Duodenal ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1, 1960</b> to <b>Dec 14, 1960</b> , that (I) (we) lost saw the deceased alive on <b>Dec 14, 1960</b> , and that death occurred at <b>3 P</b> M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <b>W.R. Cadle</b>		22c. PHYSICIAN'S NAME (Type) <b>W.R. Cadle</b>	
22d. ADDRESS <b>Emmitsburg, Maryland</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-17-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		25a. REC'D BY REGISTRAR <b>DEC 20 '60</b>	
ADDRESS <b>Thurmont, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Finner</b>	

12802

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13877 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13876

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> <span style="float: right;">35</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Maryland Avenue</b>				d. STREET ADDRESS <b>311 N. Maple Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Thomas Watts</b>				4. DATE OF DEATH Month <b>12</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-15-1880</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>12</b> Days <b>16</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R. R. Co</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George T. Watts</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Keller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Minnie Cooper, Knoxville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420-1</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>12/16/1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-20-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Boonesboro</b>		22d. LOCATION (City, town, or county) (State) <b>Boonesboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. W. Felt</b> <b>Brunswick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DEC 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1907

HANDS OF DEATH  
CEREMONY

MARYLAND

WILLIAM A. JONES

JOHN JONES

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

13870  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13877  
Item 6 Film 277 12-27-60 et

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Miss Nora M. Wise</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/4/1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>accountant, ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>power company</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Wise</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Derr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-10-2608</b>	
17. INFORMANT <b>Mrs. Anna McBride, Middletown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vase morrhage</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio-vascular Disease</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Had fall resulting in Colles Fracture, Lt. Arm</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall in Church</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>12/11</b> 1960 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Church</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> 1960, to <b>12/13</b> 1960 that (I) (we) last saw the deceased alive on <b>12/13</b> 1960, and that death occurred at <b>6:05</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>A. A. Pearre</b>		22b. DATE SIGNED <b>12/14/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. A. Pearre</b>		22d. ADDRESS <b>Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12/16/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 19 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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UNITED STATES OF AMERICA  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13878

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>				c. LENGTH OF STAY IN 1b <b>2½ years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley View Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Zoe</b> Middle <b>E.</b> Last <b>Witter</b>				4. DATE OF DEATH Month <b>December</b> Day <b>21,</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 28, 1881</b>	
9. AGE (In years lost birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min.		IF UNDER 24 HRS. Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick County, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Marshall O. Ramsbury</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ellen Ogle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-14-2927D</b>		17. INFORMANT <b>Mrs. Edgar Hawker R.F.D. # 4 Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>Essential hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential hypertension</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Frederick, Maryland</b>				20g. (County) <b>Frederick, Maryland</b>			
20h. (State) <b>Frederick, Maryland</b>				20i. (Country) <b>Frederick, Maryland</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>August 14, 1960</b> to <b>12/21, 1960</b> ; that (I) (we) lost saw the deceased alive on <b>14 December 1960</b> , and that death occurred at <b>12/21, 1960</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>James B. Thomas</b>				22b. DATE SIGNED <b>12-22-1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. James Thomas MD.</b>				22d. ADDRESS <b>228 N. Market St. Frederick, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-24-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Delaney</b>				25a. REC'D BY REGISTRAR <b>Frederick, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Harris</b>	

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